



General Assembly

January Session, 2003

***Raised Bill No. 6444***

LCO No. 3208

Referred to Committee on Insurance and Real Estate

Introduced by:  
(INS)

***AN ACT CONCERNING CONTRACTS BETWEEN MANAGED CARE ORGANIZATIONS AND PROVIDERS AND THE RECODING OF HEALTH INSURANCE CLAIMS.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1      Section 1. (NEW) (*Effective October 1, 2003*) (a) As used in this  
2      section, "contracting health plan" means (1) a managed care  
3      organization, as defined in section 38a-478 of the general statutes; (2) a  
4      preferred provider network, as defined in section 38a-479aa of the  
5      general statutes; or (3) any organization operating a workers'  
6      compensation insurance arrangement, including, but not limited to, a  
7      medical care plan established pursuant to subsection (c) of section 31-  
8      279 of the general statutes.

9      (b) Each contract for services to be provided to residents of this state  
10     entered into, renewed, extended, amended or modified on or after  
11     October 1, 2003, between a contracting health plan and a health care  
12     provider shall include provisions that (1) provide an explanation of the  
13     provider payment methodology, the information to be relied on to  
14     calculate payments and adjustments, and the process to be used to  
15     resolve disputes concerning provider payments; and (2) require the

16 contracting health plan to make available to each participating  
17 provider a copy of the fee schedule that determines the provider's  
18 reimbursement.

19       Sec. 2. (NEW) (*Effective January 1, 2004*) (a) As used in this section,  
20 (1) "managed care organization" means a managed care organization,  
21 as defined in section 38a-478 of the general statutes, (2) "provider"  
22 means a provider, as defined in section 38a-478 of the general statutes,  
23 and (3) "recode" or "recoding" means the changing, by a managed care  
24 organization on a claim submitted by a provider, of a code or group of  
25 codes for health care services for the purpose of reimbursing the  
26 provider at a lower rate. "Recode" or "recoding" includes, but is not  
27 limited to, the reduction of an evaluation or management service level,  
28 the combining of codes for two or more separate and distinct services  
29 or procedures performed on a single patient during a single office visit,  
30 the change of a code to a different classification code, or the bundling  
31 of physician services codes in any manner that conflicts with the  
32 American Medical Association's Current Procedural Terminology  
33 coding policy or instructions.

34       (b) Unless a provider agrees to recode a claim, a managed care  
35 organization or its agent shall not recode a claim submitted by a  
36 provider without first obtaining approval from an external board of  
37 review in accordance with the procedures set forth in this section.

38       (c) (1) To obtain approval for a proposed recoding from an external  
39 board of review under this section, the managed care organization or  
40 its agent shall, not later than ten days after receiving a completed  
41 claim, (A) file a written request with the Insurance Commissioner  
42 including a justification for the proposed recoding and the filing fee  
43 provided for in subdivision (2) of this subsection, and (B) provide by  
44 certified mail, facsimile transmission or electronic mail a notice of the  
45 request to the provider who submitted the claim. The request,  
46 justification and notice shall be on forms prescribed by the  
47 commissioner. Not later than January 1, 2004, the commissioner shall

48 adopt regulations, in accordance with chapter 54 of the general  
49 statutes, to establish the contents of such forms.

50 (2) The filing fee shall be twenty-five dollars and shall be deposited  
51 into the Insurance Fund established in section 38a-52a of the general  
52 statutes.

53 (3) Upon receipt of the request and appropriate filing fee, the  
54 commissioner shall assign the request for review to an external board  
55 of review established pursuant to subsection (d) of this section.

56 (4) Not later than ten days after receiving notice of a request for  
57 approval, the provider may provide to the commissioner the clinical  
58 explanation for the coding which may include copies of clinical records  
59 for the services and procedures provided. The commissioner shall  
60 forward the explanation and copies to the designated external board of  
61 review.

62 (5) Upon receipt of the request for approval and any additional  
63 materials from the commissioner, the external board of review shall  
64 complete a review of the request not later than fifteen days after such  
65 receipt. The review shall be completed in accordance with regulations  
66 which the commissioner shall adopt, not later than January 1, 2004, in  
67 accordance with chapter 54 of the general statutes, after consultation  
68 with the Commissioner of Public Health and the Managed Care  
69 Ombudsman. In such review, the managed care organization or its  
70 agent shall have the burden of proving that the proposed recoding is  
71 justified.

72 (d) To provide for such review the Insurance Commissioner, after  
73 consultation with the Commissioner of Public Health and the  
74 Managed Care Ombudsman, shall engage impartial health entities to  
75 provide medical review under the provisions of this section. Such  
76 review entities shall be known as an external board of review and shall  
77 be composed of representatives from (1) medical peer review  
78 organizations, (2) independent utilization review companies, provided

79 any such company is not related to or associated with any managed  
80 care organization, and (3) nationally recognized health experts or  
81 institutions approved by the commissioner.

82 (e) The commissioner shall accept the decision of the external board  
83 of review and shall notify the managed care organization or its agent  
84 and the provider of the decision. The decision of the commissioner  
85 shall be binding and final.

86 (f) The requirements of subdivision (15) of section 38a-816 of the  
87 general statutes shall continue to apply and shall not be affected by the  
88 procedures set forth in this section.

This act shall take effect as follows:	
Section 1	<i>October 1, 2003</i>
Sec. 2	<i>January 1, 2004</i>

***Statement of Purpose:***

To require that (1) contracts between certain health plans and health care providers include an explanation of payment methodology, a copy of the applicable fee schedule, and information concerning dispute resolution, and (2) a managed care organization obtain the approval of an independent external review board prior to recoding a claim submitted by a health care provider.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*